

When cancer hits the streets

K.I. Stajduhar RN PhD,*† A. Mollison MA,† D. Gleave MD,‡ and S.W. Hwang MD MPH§

Toby died 5 October 2015. The cause on his death certificate read “Small cell lung cancer.” He was 56.

Toby had been living rough, sleeping on the street until his cancer-riddled body could no longer tolerate the cold. He was proud to have found housing for a few months before he died. He lived in a 10×12-foot room, on a mattress on the floor. His diet consisted of two cans of Boost daily (traded for part of his disability cheque to the man down the hall who picked it up for him). His toilet was a bucket beside him on the floor. His “safety plan” when he struggled to breathe or when the pain became unbearable was to bang a stick on the floor and hope that someone in the building would hear him, because he did not have a telephone. He had no family and no friends. Toby’s cancer-filled lungs failed him. But, ultimately, poverty was what killed him.

Cancer is among the leading causes of death for homeless adults¹. Compared with the general population, homeless people experience alarmingly high rates of mortality from cancer². Significant disparities are recognized to exist in cancer risk factors, screening, diagnosis, and treatment for homeless people. What is less evident—perhaps even slightly invisible to the public eye, and even to the eyes of the health care community—is what happens with these vulnerable people who are at the end of their lives.

Despite Canada’s commitment to provide high-quality health care, health inequities remain a pressing problem. In particular, people affected by structural inequities such as inadequate housing, racialization, classism, and stigmatization because of substance use and mental illness continue to experience persistent health and health care inequities that become even more pronounced at the end of life. Although palliative care services are available in Canada for those with complex health care needs, current models of palliative care have largely not been designed to serve individuals having structural vulnerabilities. For those people, death and dying, while sometimes occurring in specialized palliative care settings, are more likely to occur in acute care. Or people die alone, outdoors, on the street and in vehicles, or in shelters or transitional housing, cared for by workers who are highly compassionate, but who have limited training and knowledge to ensure quality end-of-life care.

The mission of the Canadian Cancer Society, and for many working in cancer care, is focused on the eradication of cancer and enhancement of quality of life for people living with cancer. But for people having structurally vulnerabilities, such care seems an out-of-reach, almost far-fetched, dream. In the lead article in this issue of

Current Oncology, Henry, Dosani, Huynh, and Amirault articulate the multiple disparities facing people experiencing homelessness³. Specifically, they unpack the assumptions embedded within the delivery of health care and palliative care for that group: the presence of a home, family supports, money for ancillary care needs, and the ability to place trust in others, including their health care providers. At the individual, organizational, and structural levels, those barriers create inequalities in the way that palliative care is delivered and accessed, and they prohibit the advancement of high-quality care at the end of life.

How can palliative care needs be adequately addressed in the presence of the daily struggles that most homeless people face in meeting their basic survival needs? How are approaches to care that take into account the social discrimination, stigmatization, and negative experiences of care within the health system to be incorporated for the many cancer patients who are dying and who are also experiencing structural vulnerabilities?

Medical conditions are created and exacerbated for people who are living in dire poverty, who are sleeping rough or in unstable living situations, who have little access to food and nutrition, who are estranged from family and formalized support networks, who are using intoxicants or living with mental health conditions (or both), who are living with posttraumatic stress disorder and other effects of trauma, and who are facing discrimination, ableism, racism, and classism. When those individuals try to access care, they are often treated poorly or not treated at all. They are dismissed as “drug seeking” and can be banned from health services for poor hygiene or inappropriate behaviour. Even if such people are treated respectfully by health care professionals, the institutions they visit can serve to re-institutionalize, re-traumatize, and re-colonize them. At the end of life, those barriers—individual, organizational, systemic, and structural—prevent identification of the need for, and access to, dignified palliative care for those individuals. As in Toby’s case, once the need was identified, it was too late. He was dead.

Henry and colleagues urge us to consider models and promising approaches to care for homeless people who are at the end of life: mobile services that can reach people where they are located and are most comfortable being; respectful, nonjudgmental approaches that begin to build trust with people who largely have little reason to trust; and approaches to care that are informed by social justice perspectives, that are equity- and trauma-informed, and that consider people worthy of care⁴.

Programs are beginning to emerge across Canada: Toronto's PEACH (Palliative Education and Care for the Homeless) initiative, Calgary's CAMPP (Calgary's Allied Mobile Palliative Care Program) team, and Victoria's PORT (Palliative Outreach Resource Team) program. But those initiatives are not nearly enough. As Henry *et al.* astutely point out, public health approaches to palliative care—and to care for cancer patients who are dying—have the potential to place greater attention on the social determinants of health, making visible the factors that result in poor health outcomes and increased rates of morbidity and mortality for individuals who are structurally vulnerable. Such an approach might also help practitioners to shift their gaze upstream and to consider how the health care system as a whole can do more to prevent and treat cancer in the homeless population. Until then, we can expect alarmingly high mortality rates from cancer in the homeless population to continue into the foreseeable future.

ACKNOWLEDGMENTS

This work is supported by funds from the Canadian Institutes of Health Research (FRN no. 133578).

CONFLICT OF INTEREST DISCLOSURES

We have read and understood *Current Oncology's* policy on disclosing conflicts of interest, and we declare that we have none.

AUTHOR AFFILIATIONS

*School of Nursing, University of Victoria, †Institute on Aging and Lifelong Health, University of Victoria, and ‡Victoria Cool Aid Society, Victoria, BC; and §Centre for Urban Health Solutions, St. Michael's Hospital, Toronto, ON.

REFERENCES

1. Baggett TP, Hwang SW, O'Connell JJ, *et al.* Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. *JAMA Intern Med* 2013;173:189–95.
2. Hwang SW, Orav EJ, O'Connell JJ, Lebow JM, Brennan TA. Causes of death in homeless adults in Boston. *Ann Intern Med* 1997;126:625–8.
3. Henry B, Dosani N, Huynh L, Amirault N. Palliative care as a public health issue: understanding disparities in access to palliative care for the homeless population living in Toronto, based on a policy analysis. *Curr Oncol* 2017;24:187–91.
4. Reimer-Kirkham S, Stajduhar K, Pauly B, *et al.* Death is a social justice issue: perspectives on equity-informed palliative care. *ANS Adv Nurs Sci* 2016;39:293–307.